The Health of New Hampshire's Community Hospital System

A Financial Analysis

Littleton Hospital Association




Office of Planning and Research
New Hampshire Department of Health and Human Services
129 Pleasant Street • Concord, New Hampshire 03301
www.dhhs.state.nh.us

An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

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Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire.*

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

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For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

LITTLETON HOSPITAL ASSOCIATION
LITTLETON, NEW HAMPSHIRE
1993 – 1999 FINANCIAL ANALYSIS

Littleton Hospital Association is a 49-bed acute-care facility in Grafton County [3]. As of 1997, private insurers followed by Medicare represented the largest percentage of payers for inpatient discharges (44 and 37%, respectively)[4].

The Littleton Hospital Association is a stand-alone hospital with consolidated physician practices.

Summary of Financial Analysis 1993-98
This small hospital exhibited strong growth in profitability, liquidity and solvency over the period, though it increased its level of long-term debt considerably in 1998. Despite the increased level of debt, the hospital appears capable of meeting debt service needs from its strong operating performance and substantial cash reserves.

Cash Flow Analysis 1993-98
The hospital generated more than half of its cash internally, but used long-term borrowing to augment equity sources of capital. Cash generated internally from net income and depreciation represented 46% of total cash sources, while long-term borrowing in 1998 generated 44% of the total cash over the period.

Cash was used mostly to increase marketable securities (67% of total cash uses), half of which has been set aside in trustee-held funds. In 1998, the hospital had 415 days cash (short-term and board designated) available.

The hospital spent one-third of its cash on investment in property, plant and equipment (PP&E). Though this level of investment was 62% more than depreciation expense over the period, the average age of plant increased and was slightly above the state median as of 1998, at 10 years.

Ratio Analysis 1993-98[5]
Profitability
Profitability was very strong in recent years and was driven by improved operating margins. Recent operating margins increased well above 1995 and earlier levels along with increases in the markup ratio that were not offset by payer discounts.

The hospital's most profitable year in 1996 produced 13% total margins, almost entirely attributable to dramatic growth in operating income following a 36% increase in the markup of price over cost (from 58 to 79%).

Nonoperating revenues were consistently important to bolstering the bottom line. Over this time period, investment income grew three-fold, reflecting the hospital's increasing level of marketable securities. As a result, the hospital was able to maintain 10% total margins in 1996-1998.

[3] The 1998 American Hospital Association Guide.
[4] 1997 data from the State of New Hampshire Department of Health and Human Services.
[5] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

Liquidity
The hospital's liquidity ratios are favorable until a sudden increase in days in accounts receivable in 1998, coupled with a sharp increase in current liabilities, in part due to the increase in long-term debt, current portion. Vendor payments also slowed significantly in 1998. Despite this, days cash on hand from all sources increased to 417 days in 1998, up from 238 in 1997 (due again primarily to the additional borrowing).

Capital Structure
Trends in the level of debt and ability to pay reflected the hospital's $15M debt issuance in 1998. Improved solvency due to strong profitability and equity growth over the period helped make it possible for this small hospital to secure this debt.

In 1998, the hospital's equity financing ratio (equity/total unrestricted assets) dropped to 43% from 69% the previous year. The ability to cover debt also dropped with the change in capitalization. The cash flow to total debt measure dropped from 39 to 13% between 1997 and 1998. Coverage ratios do not indicate any imminent problems, however, as debt service coverage ratios show that the hospital can easily meet debt principal and interest payments, even with cash from operating income alone.

Charity Care and Community Benefits
Charity care reported as charges forgone ranged from 1.7 to 3.3% of gross patient service revenues over the period 1993 to 1998. This amount of charity care met the estimated value of the hospital's tax exemption prior to 1994. In 1995 and 1998, the hospital met the estimated tax value with the inclusion of 50% bad debt. In the remaining years, this benchmark was met when 100% bad debt was included.

The hospital did not report any additional community benefits in the footnotes to its financial statements.

In addition to charity care, the hospital offers HIV/AIDS services[1], which may be considered an additional charitable benefit to the community.

Cash Flow Analysis 1993 - 1999

A majority of cash generated (46%) comes from long-term debt, most of which has been taken on in the last 2 years. Most of the remaining cash generated comes from non-cash adjustments (depreciation and amortization) (18%) and operating income (11%), followed by non-operating gains (8%). Two percent has been transferred from restricted funds to unrestricted funds.

The hospital used cash primarily to invest in marketable securities (57%). It has also invested $17M (38%) in property, plant, and equipment (PP&E). This investment is 114% larger than the depreciation expense, which contributed to the decrease in the average age of plant from 10.1 to 9.8 years.

1999 Ratio Analysis

Profitability

Although the period from 1993 to 1998 was marked by strong operating profits, 1999 shows a sharp decline in operating margin from 6% in 1998 to –1% in 1999. Part of the loss is due to a steady decline in the markup, while the deductible ratio remained steady. The primary factor in the 1999 loss was a record 18% increase in operating expenses. A doubling of bad debt expense also contributed to the poor 1999 results. Strong non-operating revenues brought the 1999 total margin up to 5%.

Liquidity

Considering only current assets, the hospital has 239 days cash on hand; however 235 of those days of cash represent trustee-held funds held since 1998 with the new debt issue. Presumably, the trustee-held assets are set aside for capital investment (plant and equipment) purposes. When non-current board-designated investments are included, the days cash on hand increases to 444 days of cash on hand (205 days excluding current trustee-held assets).

Excluding the large current trustee-held investments, the current ratio is 1.58. This is an adequate ratio for covering current liabilities, although the asset mix is not ideal. In particular, average days in accounts receivable was 98 days in 1999, a level that is quite high (unfavorable). Littleton pays vendors in 50 days, which is higher than most hospitals in New Hampshire.

Capital Structure

The hospital has moved into a higher-risk position with an equity financing ratio of 0.38 (among the very lowest in the state and well below the national average), primarily due to issuing new debt in 1998. Debt service coverage in 1999 dropped to below 1.0, an indicator of potential problems for the hospital. However, cash balances are available that roughly equal the amount of long-term debt. Still, it is clear that the hospital will have to control its operating expenses to resume financial stability.

Charity Care and Community Benefits

In 1999, charity care reported as charges forgone represented 2.59% of gross patient service revenue. This is down from 2.91% in 1998. Also in 1999, bad debt represents 6.70% of the GPSR – nearly double the 1998 amount of 3.97%.

Summary

A one-year decline in profitability should not normally be cause for concern, especially considering Littleton's high level of profitability from 1993-1998, and at a 5% margin, the hospital is still profitable. However, the hospital's high level of debt, combined with its slow receivables collection, suggests that Littleton is having some financial difficulty.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health